MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

05044

Reg. Dist. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Bldg. 509
How long in hospital or institution? dead on admission

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 212 North Durham Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie K. Alston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	Married

9.(b) Name of husband or wife: Roger Alston
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 16, 1912

8. AGE: Years	Months	Days	If less than one day
33	2	9	hrs. min.

9. Birthplace: Franklinton, North Carolina
(Town, county, and state)
10. Usual occupation: Munitions Handler
11. Industry or business: Industry

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Roger Alston
Address: 212 N. Durham St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: Brooklyn, Md
18. Funeral director: Elroy A. Wilson
Address: 1000 Bdantlegan

19. 5/29 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 45 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on dead on admission 19

Immediate cause of death	DURATION
chemical burns	Instant
Due to: White Phosphorus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: May 25, 1945
Where did injury occur? Edgewood Arsenal, Harford, Md.
(City or town) (County) (State)
Industry
injured at home, farm, industry, public place (where?)
Means of injury: Explosion. Injured at work? yes

23. SIGNATURE: Harold C. Palmer M.D.
DEPUTY MEDICAL EXAMINER
HARFORD COUNTY
M. D. or other
Address: Bel Air, Md. Date signed: 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1952

05045

CERTIFICATE OF DEATH

Reg. Dist. No. 188

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred:
Building 509
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: — Harf
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Maude B. Bedford

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife: James R. Bedford
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): July 15, 1898

8. AGE: Years	Months	Days	If less than one day
46	10	10	....hrs. ....min.

9. Birthplace: Darlington, Maryland (Town, county, and state)
10. Usual occupation: Munitions Handler
11. Industry or business: Industry

FATHER
12. Name: J. Milton Warner
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Jane Warner
15. Birthplace: unknown

16. Informant: Mrs. Leonard Bunkins
Address: Darlington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28 1945 (month) (day) (year)
Cemetery or crematory: Darlington Cemetery
Location: Darlington, Maryland
18. Funeral director: H. S. Bailey
Address: Darlington Md
19. May 26 1945 (Date rec'd by registrar) Marie M. Mowbray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h....alive on dead on admission 19....

Immediate cause of death	DURATION
Chemical burns	instant
Due to: White Phosphorus burns	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. ....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: May 25, 1945
Where did injury occur? Edgewood Arsenal, (City or town) Md., (Conty) Harford (State)
Injured at home, farm, Industry, public place (where?): Industry
Means of injury: Explosion Injured at work? yes

DEPUTY MEDICAL EXAMINER
HARFORD COUNTY

23. SIGNATURE: Gerald C. Palmer MD M. D. or other
Address: Bel Air, Md Date signed: 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of birth date of deceased is shown on

FILE No. G 95 JUN 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

CERTIFICATE OF DEATH

05046/182
Reg. Dist. No.

1. PLACE OF DEATH:
County: Harford, Md
City or town: Fallford
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2828 Woodbrook Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lydia Eva Boyd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: David F Boyd

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 13, 1877 1867

8. AGE: Years: 78 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Harford Co
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Edwin McCune
13. Birthplace: Harford Co, Md

MOTHER
14. Maiden name: Leah Nagle
15. Birthplace: Harford Co. Md

16. Informant: Mrs Onley Dayhoff
Address: Bel Air, Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28/45 (month) (day) (year)

Cemetery or crematory: Mt Zion
Location: Fountain Green

18. Funeral director: Deaver & Foster
Address: Bel Air Md

19. 5-26 19 45 (Date rec'd by registrar) Priscilla Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 19.. to May 25 1945
and that I last saw h.. alive on May 25 1945

Immediate cause of death: Cent Pulmonary Edema — DURATION: 1 hr.
Due to: Arterio sclerotic Cv. Disease — 2 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Horsey M. D. or other
Address: Churchville, Md Date signed: May 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(195-2)

65147

Reg. Dist. No. 30180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? - - -
Hospital, Institution, or street address where death occurred:
Building No. 509
How long in hospital or institution? - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 412 Oxford Court
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Clarice B. Catlin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband or wife: Elmer Catlin
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): 5 April 1917

8. AGE: Years	Months	Days	If less than one day
28	1	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Munitions Handler
11. Industry or business: Edgewood Arsenal, Md

FATHER
12. Name: Walter Blackston
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Mary Chase
15. Birthplace: Baltimore, Maryland

16. Informant: Grace Tilghman
Address: 287 Nostrand Ave, Brooklyn, N. Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1945 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Pk.
Location: Baltimore Co. Md.

18. Funeral director: Wm. George A. Holland
Address: 1631 Druid Hill Ave.

19. 5/29/45 (Date rec'd by registrar) 19 45 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 45, at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chemical burns	2 hrs
Due to: White Phosphorus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident Date of: 25 May 1945
Where did injury occur? Edgewood Arsenal, Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Explosion Injured at work? Yes

23. SIGNATURE: Harold C. Palmer M.D.
DEP. MEDICAL EXAMINER HARFORD COUNTY
Address: Bel Air, Md. M. D. or other
Date signed: 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05048 Reg. Dist. No. 185

P

1. PLACE OF DEATH

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford.

City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #2
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Marie Cerny

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or ~~wife~~ Alois Cerny (deceased)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 29 1867

8. AGE: Years 77 | Months 5 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: Austria - Hungary
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Joseph Mynar

13. Birthplace: Hungary

MOTHER 14. Maiden name: Barbara Kacafir

15. Birthplace: Hungary

16. Informant: Daughter Mrs Bessie Shalone

Address: Edgewood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/45 (month) (day) (year)

Cemetery or ~~crematory~~ Oak Hill

Location: Philadelphia Rd. Balto. Md.

18. Funeral director: Charles E. Schimunek

Address: 2601 E. Madison Street

19. 5/28 1945 (Date rec'd by registrar) C. U. Hedrick per L.P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-24 1945 at 2.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-21 1945 to 5-24 1945 and that I last saw h~~e~~ ex alive on 5-24 1945

Immediate cause of death	DURATION
Cardiac failure	
Due to Hypertensive Disease of Kidney	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypernephroma of kidney

Date of op. 5-24-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles W. Frain M.D. M. D. or other

Address Havre de Grace, Md Date signed 5-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (528)

CERTIFICATE OF DEATH

T 05049

Reg. Dist. No. 184

1. PLACE OF DEATH:

County Harford

City or town Whiteford, Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 wks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Harford

City or town Whiteford Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henrietta W. Chandlee

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife John V. Chandlee

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aug. 30 - 1861

8. AGE: Years 83 Months 8 Days 20 If less than one day ... hrs. ... min.

9. Birthplace York Co. Pa. (Town, county, and state)

10. Usual occupation Dressmaker

11. Industry or business

FATHER 12. Name Joseph H. Wheeler

13. Birthplace Harford Co. Md.

MOTHER 14. Maiden name Rachel Ann Taylor

15. Birthplace Harford Co. Md.

16. Informant Thomas H. Wheeler

Address Delta, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23-1945 (month) (day) (year)

Cemetery or crematory Slate Ridge Cem.

Location Delta Pa.

18. Funeral director Hubert P. Harkins

Address Delta, Pa.

19. May 22 1945 (Date rec'd by registrar) Carl E. Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945, at 2300 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1943, to May 20 1945

and that I last saw her alive on May 19 1945

Immediate cause of death hypertensive heart — DURATION

Due to arteriosclerosis

Due to

Other conditions cancer of the urinary bladder (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Castleton

Date signed [illegible]

T 05050

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 18-5

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
Street No.: Post Road Est (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Robert L. Christy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband ~~or wife~~: Sarah Christy
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 12-1869

8. AGE: Years	Months	Days	If less than one day
75	6		..... hrs. ..... min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Day Laborer
11. Industry or business
FATHER 12. Name: William G. Christy
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Martha Reddick
MOTHER 15. Birthplace: Virginia
16. Informant: Lizette P. Gribb
Address: Aberdeen Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15-1945 (month) (day) (year)
Cemetery or crematory: Union M. E.
Location: Near Aberdeen Md.
18. Funeral director: Henry Tagring Sons
Address: Aberdeen Md.
19. May 15 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 1945, at 6:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1945 to May 12 1945
and that I last saw h.. alive on May 12 1945

Immediate cause of death	DURATION
Arteri-sclerosis	12-7-44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Claude L. Lawrence M.D. M. D. or other
Address: Havre de Grace Date signed: 5-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

Reg. Dist. No. 1285 — 050585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: none
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Allen W. Clark

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Nellie Clark

6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): 4/2/18

8. AGE: Years	Months	Days	If less than one day
27	1	8	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: —

FATHER — 12. Name: James R. Clark

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sadie Anderson

15. Birthplace: Maryland

16. Informant: Anderson Clark

Address: Chester, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/11/45 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace

18. Funeral director: Pennington & Son

Address: Havre de Grace

19. May 10 1945 (Date rec'd by registrar) H. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945 at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Gunshot wound cerebrum	½ hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: May 9 1945

Where did injury occur? Perryville (City or town) Cecil (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Shot self Injured at work? No

23. SIGNATURE: Gerald C. Palmer M.D.
Deputy Medical Examiner
Harford County
M. D., or other

Address: Bel Air, Md. Date signed: 5/9/45

Evidence for change of age is shown on FILM No. G95 MAY 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

T 05952

Reg. Dist. No. 182.

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Md County: Harford Co.
City or town: Bel Air Md
(If outside city or town limits, write RURAL and give neareet town)
Street No. Broadway
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Georgia Dara Coale

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph R Coale
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 31 1875

8. AGE:	Years	Months	Days	If less than one day
	69 70	9	20	..... hrs. ..... min.

9. Birthplace: Baltimore Co
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:

FATHER
12. Name: Daniel Ehrhart
13. Birthplace: Balto, Co.

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Joseph R Coale
Address: Bel Air, Md

17. Burial (Burial, cremetion, or removal. Which?) Date thereof: May 14 1945 (month) (day) (year)
Cemetery or crematory: Friendship Methodist
Location: Near Fallston
18. Funeral director: Deaver & Foard
Address: Bel Air, Md.

19. 5/12 1945 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/11 1945, at 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 19.. to 5/11 1945 and that I last saw her alive on 5/11/45 19..

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 wks
Due to	
Due to	
Other coodiltons	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C M Hopkins M. D. or other
Address: Bel Air Md Date signed 5/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

05053

Reg. Dist. No. 180

P

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? –
Hospital, institution, or street address where death occurred:
Building 509
How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: –
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 774 Saratoga Street
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Annie C. Cook

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): July 12, 1899

8. AGE: Years	Months	Days	If less than one day
45	10	13	...hrs. ...min.

9. Birthplace: Crosshill, Lawrence County, So. Car.
(Town, county, and state)

10. Usual occupation: Munitions Handler

11. Industry or business: Industry

FATHER
12. Name: Willis Calwrie
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Rachel Calwrie
15. Birthplace: South Carolina

16. Informant: Roy Calwrie
Address: 905 Warner Street, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)
Cemetery or crematory: Mt Auburn Ct
Location: Balto City

18. Funeral director: Daniel L Burns & Son
Address: 10 E Montgomery St

19. 5/28/45 (Date rec'd by registrar) A.W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 45, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on dead on admission 19...

Immediate cause of death	DURATION
Chemical burns	Instant
Due to: White Phosphorus burns	
Due to: –	
Other conditions: –	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op.
Autopsy results: –
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: May 25, 1945
Where did injury occur? Edgewood Arsenal, Harford, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Explosion Injured at work? yes

23. SIGNATURE: Leland C Palmer M D
M. D. or other
Address: Bel Air, Md. Date signed: 6/25/46

DEPUTY MEDICAL EXAMINER HARFORD COUNTY

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T5054

93d

Reg. Diat. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 262 Wilson St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Janice M Cooling

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife: Kenneth Cooling

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1903

8. AGE:	Years	Months	Days	If less than one day
	42	4	0	..... hrs. ..... min.

9. Birthplace: Whiteford, Harford, Md.

(Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business: Public School

FATHER 12. Name: Joel Harry

13. Birthplace: Md.

MOTHER 14. Maiden name: Missouri Sanders

15. Birthplace: Md.

16. Informant: Mr Kenneth Cooling

Address: 262 Wilson St. Havre de Grace Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/2/45 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. June 2 19 45 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 45, at 1145 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-30 19 45, to 5-31 19 45 and that I last saw h-r alive on 5-31 19 45

Immediate cause of death	DURATION
Coronary occlusion	3 days
Due to: Hypertensive cardiovascular disease	yrs.
Due to: Arteriosclerotic heart disease	yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles N Frazier MD

M. D. or other

Address: Havre de Grace MD Date signed 5-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

(1505:45) Reg. Diat. No.

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year, 8 Months
Hospital, institution, or street address where death occurred:
Station Hospital, Aberdeen Proving Ground, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2523 Taylor Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: HOWARD ELLSWORTH DAVIS

3. (b) Social Security Number: 213-09-9836

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Corrie Vogel Davis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 24 July 1883

8. AGE: Years	Months	Days	If less than one day
61	10	4	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Engineering Contract Building

FATHER
12. Name: Jacob Councilman Davis
13. Birthplace: ~~Deceased~~ Balto - Md.

MOTHER
14. Maiden name: Ella Russell
15. Birthplace: ~~Deceased~~ Balto - Md.

16. Informant: The Surgeon
Address: Sta Hosp, Aberdeen Proving Ground, Md.

17. Burial (Burial, cremation, or removal—Which?) Date thereof 5-6-2-45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto - R. J. Luch - Funeral Dir.
18. ~~Funeral director~~ Witnessed by: Benedetto A. Cerilli
Address: BENEDETTO A. CERILLI, 2nd Lt. MAC
19. 5/31 (Date rec'd by registrar) 19 45 R. W. Hodnick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 May 19 45, at 1:27 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12:40 PM 29 May 19 45, to 1:27 PM 29 May 1945 and that I last saw him alive on 29 May 1945 19

Immediate cause of death	DURATION
Occlusion, coronary	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Confirm cause of death
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

GERALD C. PALMER MD
Deputy Medical Examiner
Harford County
23. SIGNATURE: Gerald C. Palmer M.D. M. D. or other
Address: Bel Air, Md. Date signed: 30 May 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05056

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 minutes
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Eller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1945

8. AGE: Years | Months | Days | If less than one day: hrs. 15 min.

9. Birthplace: Darlington, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Rafe S. Eller
13. Birthplace: Wilkes County, North Carolina

MOTHER
14. Maiden name: Carrie Belle Nichols
15. Birthplace: Johnson County, Tenn.

16. Informant: Mrs. Rafe S. Eller,
Address: Darlington, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory
Location

18. Funeral director
Address

19. 6/5 1945 Priscilla Fowwood
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30, 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1945, to May 30, 1945 and that I last saw him alive on May 30, 1945

	DURATION
Immediate cause of death: Premature birth	15 minutes
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson, M. D. or other
Address: Forest Hill, Maryland. Date signed: 6-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 05057781

1. PLACE OF DEATH:

County: Harford

City or town: Rural Havre de Grace Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Frank H. Elsner

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 14 - 1869

8. AGE: Years 75 | Months 11 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Glendale Ohio
(Town, county, and state)

10. Usual occupation: Farmer & Farmer

11. Industry or business

FATHER 12. Name: John Elsner

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Christina Roff

MOTHER 15. Birthplace: Germany

16. Informant: Mrs. Augusta C. Elsner

Address: Havre de Grace Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7 1945 (month) (day) (year)

Cemetery or crematory: St Paul Lutheran

Location: Near Aberdeen Md.

18. Fuoeral director: Henry Tarring & Sons

Address: Aberdeen, Md.

19. May 7 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 1945 at 12:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1944 to May 5 1945 and that I last saw h... alive on May 5 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: Hypertension	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stanley J. Foley M.D.
M. D. or other

Address: Havre de Grace Md. May 7/45
Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

05058

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Rural — Fountain Green
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Near Fountain Green (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ginevra Fowlkes Evans

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: James T Evans
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 10 - 1868

8. AGE: Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: Tapia, NC
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER — 12. Name: Dr Charles G Fowlkes
13. Birthplace: Va
MOTHER — 14. Maiden name: Amanda Toliver
15. Birthplace: N.C
19. Informant: Mrs Lucia E Marsh
Address: Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1945 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Fountain Green, Md
18. Funeral director: Dean & Foster
Address: Bel Air, Md
19. 5/17 (Date rec'd by registrar) 1945 Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1945 at 9:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1943, to May 16 1945
and that I last saw her alive on May 16 1945

Immediate cause of death	DURATION
Chr. Myocardial Disease	2 yrs.
Diabetes Mellitus	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wilma P. Hudson M. D. or other
Address: Forest Hill, Md. Date signed: 5/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05059

Reg. Dist. No. 185

GIVE CORPORATE LIMITS OF

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 127 So. Stokes, St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 So. Stokes St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George Baker Fadeley

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Dorris Fadeley
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): June 20, 1887
8. AGE: Years: 57 Months: 10 Days: 18 If less than one day: ___ hrs. ___ min.
9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Bar Tender
11. Industry or business:
FATHER 12. Name: Charles C. Fadeley
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Maham
15. Birthplace: Md.
18. Informant: Mrs. Dorris Fadeley
Address: Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.
18. Funeral director: R Madison Mitchell
Address: Havre de Grace, Md.
19. 5-10 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1945, at 4 A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10, 1944, to May 8, 1945
and that I last saw h— alive on May 6, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	
Due to:	
Due to: Carcinoma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J Fadeley M.D. M. D. or other
Address: Havre de Grace Date signed: 5-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

05060

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1945 62 85

1. PLACE OF DEATH:
County: Harford Co
City or town: Bel Air, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 S Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Francis Finneran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Eugenie Dick Finneran
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12 / 1883

8. AGE: Years: 62 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Boston Mass
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business

FATHER 12. Name: John K Finneran
13. Birthplace: Mass

MOTHER 14. Maiden name: Anna McBride
15. Birthplace: Mass

16. Informant: Mrs Eugenie D Finneran
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 / 45 (month) (day) (year)
Methodist.
Cemetery or crematory: Southern, Dublin, Md
Location: Dublin Md

18. Funeral director: Deaver Lodge
Address: Bel Air, Md

19. 6/1 1945 Priscilla Fawcett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Gerald C Palmer M.D.
Deputy Medical Examiner
Harford County
M. D. or other
Address: Bel Air, Md Date signed 5/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-d)

05061

CERTIFICATE OF DEATH

Reg. Dist. No. 188

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 1 hr - 25 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Magnolia

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Alice Franklin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Peter Franklin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 10 1875

8. AGE: Years: 69 | Months: 5 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Edgewood Maryland (Town, county, and state)

10. Usual occupation: House Maid

11. Industry or business

FATHER

12. Name: Daniel Peters

13. Birthplace: Maryland

MOTHER

14. Maiden name: Missouri Turner

15. Birthplace: Maryland

16. Informant: Blanche Beauty

Address: Magnolia Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer Baptist

Location: Magnolia Md

18. Funeral director: Howard K. McCormick Son

Address: Aberdeen Md

19. May 26 1945 (Date rec'd by registrar) Marie M. Mondale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 May 1945, at 9:25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8:00 PM 24 May 1945, to 9:25 PM 24 May 1945

and that I last saw h.. alive on 24 May 1945

	DURATION
Immediate cause of death: cerebral hemorrhage	4 hours
Due to: prolonged hypertension plus arteriosclerosis	several years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Robert R. Commons, Lt M.C., A.U.S. M. D. or other

Address: Sta. Hosp., Edgewood Arsenal, Md. Date signed: 24 May 45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05662

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Harford
City or town: Rural – Bel Air
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Maryland Convalescent Home
How long in hospital or institution? 1 yr. 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. #8 S. Rogers St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: J. Harry Gibson

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: E. Rubena Corson
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Aug. 3rd 1868

8. AGE: Years	Months	Days	If less than one day
76	8		hrs. min.

8. Birthplace: Clarksburg Md.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Retired
FATHER 12. Name: John Henry Gibson
13. Birthplace: Clarksburg Md.
MOTHER 14. Maiden name: Mary Linda Murphy Gibson
15. Birthplace: Clarksburg, Md.
16. Informant: Mrs. E. Rubena Gibson
Address: #8 S. Rogers St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4, 1945 (month) (day) (year)
Cemetery or crematory: Grove Cemetery
Location: Aberdeen
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.
19. 5/3 19 45 (Date rec'd by registrar) Priscilla Fawcett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 – 1945 at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25th 1945 to May 1 1945
and that I last saw him alive on May 1 – 1945

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	8 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 5/2/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

T 05063

Reg. Diat. No. 181

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred:
Station Hospital, Aberdeen Prov Grd, Md.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County

City or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2114 W. Diamond St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME ROOSEVELT HICKMAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Married

6.(b) Name of husband or wife Emma

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7 February 1907

8. AGE: Years	Months	Days	If less than one day
38	3	11	..... hrs. ..... min.

9. Birthplace Greensboro, North Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Navy Yard

FATHER 12. Name John R. Hickman

13. Birthplace South Carolina.

MOTHER 14. Maiden name Pateley Hickman

15. Birthplace South Carolina.

16. Informant The Surgeon

Address Aberdeen Proving Ground, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 22 45 (month) (day) (year)

Cemetery or crematory

Location Philadelphia, Pa

18. Funeral director Elmer E. Bedford

Address Havre de Grace, Md.

19. May 22 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 May 1945, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 May 1945, to 19 May 1945 and that I last saw him alive on 19 May 1945

Immediate cause of death	DURATION
Acute pulmonary oedema	
Due to liver, abscess	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.S. Mulman Capt MC. M. D. or other

Address A.P.G. Md. Date signed 21 May '45

I have received the remains of the above in good condition -

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05064

Reg. Diat. No. 184

1. PLACE OF DEATH:

County: Harford

City or town: Cardiff

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Cardiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Thomas Rushton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~May~~ Roberta Rushton

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 18 80

8. AGE: Years: 65 | Months: 1 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Whitehall Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Quarry Work

FATHER — 12. Name: Patrick Rushton

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Matilda Tally

MOTHER — 15. Birthplace: Ireland

18. Informant: Lucille E. Rushton

Address: Cardiff Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof: May 12 1945 (month) (day) (year)

Cemetery or crematory: St Mary

Location: Pylesville Md

18. Funeral director: J. Howard Rutt

Address: Forest Grove Pa

19. May 11 1945 (Date rec'd by registrar) Carl E. Knapp Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1945 at 6.00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945 to May 10 1945 and that I last saw h... alive on May 8 1945

Immediate cause of death	DURATION
Coronary occlusion, Hypertension	
Due to Atherosclerosis of the coronary arteries	
Due to Coronary condition	
Hypertensive Heart	
Due to and gallbladder stones	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

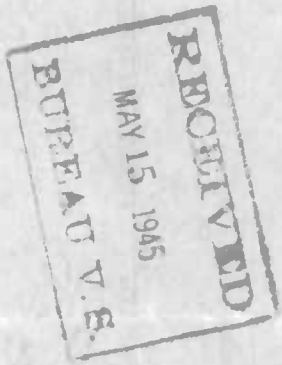
Address: Cardiff Md Date signed: 5-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 5 March 17



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BD)

CERTIFICATE OF DEATH

T 05065

Reg. Diat. No. 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN, RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Rural- Bel Air R. D. #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Harford
City or town: Rural- Bel Air R. D. #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Robert Henry Ireland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Molly Page Ireland
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): July 13, 1874

8. AGE:

Years	Months	Days	If less than one day
70	10	3	— hrs. — min.

9. Birthplace: Talbot Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: James Ireland
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Eliz. Galt
15. Birthplace: Md.

18. Informant: Mrs. Molly Page Ireland
Address: Bel Air, Md. R.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19 1945 (month) (day) (year)
Cemetery or crematory: Oak Grove Baptist Ch. yd.
Location: Harford Co. Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. May 18 19 45 Berthe B. Knight
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 19 45, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to May 16 19 45
and that I last saw him alive on May 15 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs
Due to Arteriosclerotic C.V. Disease	6 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Hockley M.D.
Address: Churchville Md. Date signed May 17
M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

B5066

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 yrs.
Hospital, institution, or street address where death occurred: 125 S. Rogers St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 125 S. Rogers St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Oscar L. Jacobs

3. (b) Social Security Number: 219-05-9447

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian O. Gallup
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): March 22, 1890

8. AGE:

Years	Months	Days	If less than one day
55	1		hrs. min.

9. Birthplace: Bruceton, Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Store Keeper U.S.G.
11. Industry or business: Aberdeen Proving Ground

FATHER
12. Name: William H. Jacobs
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: C. Letitia LaRue
15. Birthplace: Pennsylvania

16. Informant: Mrs. Lillian O. Jacobs
Address: 125 S. Rogers St. Aberdeen

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1945 (month) (day) (year)
Cemetery or crematory: Babers Cemetery
Location: Aberdeen, Md.

18. Funeral director: Henry Taxing & Sons
Address: Aberdeen, Md.

19. May 18 1945 (Date rec'd by registrar) Nellie L. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 25 1945, to May 13 1945, and that I last saw h... alive on May 13 1945

Immediate cause of death: Coronary Thrombosis	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: G B Gantrum M D
M. D. or other
Address: Aberdeen Date signed 5-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05067

CERTIFICATE OF DEATH

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W Va County:
City or town: Bluefield
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Clara E. Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: S. T. Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 1 1892

8. AGE: Years	Months	Days	If less than one day
53	2	28	hrs. min.

9. Birthplace: Welch W. Va
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: /

FATHER
12. Name: George Simpson
13. Birthplace: W. Va

MOTHER
14. Maiden name: Susie Mullens
15. Birthplace: W. Va

16. Informant: Margie Hurley Johnson
Address: Abingdon Maryland

17. Transportation
(Burial, cremation, or removal. Which?)
Date thereof: May 30 1945
(month) (day) (year)

Cemetery or crematory: S. T. Johnson
Location: 337 Bluefield Ave., Bluefield W. Va.

18. Funeral director: Howard K. McComas Funeral Home
Address: Abingdon Maryland

19. May 30 1945
(Date rec'd by registrar)
Maisie M. Mouldale
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 , to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D.
Deputy Medical Examiner
M. D. or other
Address: Belair, Md. Harford County Date signed: 6/29/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 05068/85

1. PLACE OF DEATH:

County Harford

City or town Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Bldg. 509

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 Battle Street, Edgewood, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary Florine Johnson

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 15, 1922

8. AGE: Years	Months	Days	If less than one day
23	1	10	...hrs. ...min.

9. Birthplace Nickson, Georgia
(Town, county, and state)

10. Usual occupation Munitions Handler

11. Industry or business

FATHER
12. Name Croft Johnson
13. Birthplace North Carolina

MOTHER
14. Maiden name Pearl Johnson
15. Birthplace North Carolina

16. Informant Roosevelt Standback (brother-in-law)
Address 38 Battle Street, Baltimore, Md.

17. Removal-Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)
Cemetery or crematory Rockingham Cem.
Location Richmond, V. A. C.

18. Funeral director T. Madison Mitchell
Address Havre de Grace, Md.

19. May 27 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945 at 4P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...
and that I last saw h...alive on dead on admission 19...

Immediate cause of death	DURATION
Chemical burns	Instant
Due to White Phosphorus	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of May 25, 1945
Where did injury occur? Edgewood Arsenal, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) industry
Means of injury Explosion Injured at work? yes

23. SIGNATURE Deputy Medical Examiner M.D.
DEPUTY MEDICAL EXAMINER
HARFORD COUNTY
Address Bel Air, Md. M. D. or other
Date signed 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 29 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1043)

CERTIFICATE OF DEATH

05069 / 80
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? –

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Germany County: –

City or town: Bremen
(If outside city or town limits, write RURAL and give nearest town)

Street No. –
(If rural, give LOCATION)

2.(a) If veteran, name war –

3.(a) FULL NAME: MAEHL, PAUL

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.): – 1923

8. AGE: Years	Months	Days	If less than one day
22	–	–	____ hrs. ____ min.

9. Birthplace: Bremen, Germany
(Town, county, and state)

10. Usual occupation: Soldier (Prisoner of War)

11. Industry or business: German Army

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Interment: Station Hospital
Address: Edgewood Arsenal Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31 1945 (month) (day) (year)
Cemetery or crematory: P.O.W. Cemetery
Location: Camp Meade, Md

18. Funeral director: Howard K. McKenna Jr.
Address: Aberdeen Md

19. May 31 1945 (Date rec'd by registrar) Marie M. Medsker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 19 45, at 10.50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 19 45, to May 29 19 45 and that I last saw him alive on May 29 19 45

Immediate cause of death	DURATION
Meningitis, anterior and middle chambers, localized	unknown
Due to: Secondary to Acute frontal sinusitis	
Due to: –	
Other conditions: –	

(Include pregnancy within 3 months of death)

Major findings of operations: –

Date of op. –

Autopsy results: confirm diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: – Date of –

Where did injury occur? – (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): –

Means of injury – Injured at work? –

23. SIGNATURE: Robert E. Kelly MD MC
ROBERT E. KELLY, Capt. MC M. D. or other

Address: Station Hospital, Edgewood Arsenal, Maryland Date signed: May 29, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05070 (82)

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Bldg. 509

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 704 N. Eden St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CLAUDIA McGHEE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 12, 1923

8. AGE:

Years	Months	Days	If less than one day
22	3	13	hrs. min.

9. Birthplace: Rocksboro, North Carolina
(Town, county, and state)

10. Usual occupation: Munitions Handler

11. Industry or business

FATHER
12. Name: Thomas McGhee
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Elizabeth McGhee
15. Birthplace: North Carolina

16. Informant: Joseph McGhee
Address: 704 N. Eden St

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5/27/45 (month) (day) (year)

Cemetery or crematory:

Location: Milton N.C.

18. Funeral director: Joseph E. Lake, Jr.
Address: 1304 N. Central Ave

19. 5/26/45 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 45 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19.. to 19..
and that I last saw h alive on Dead on admission 19..

Immediate cause of death	DURATION
Chemical burns	Instant
Due to: White Phosphorus	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: May 25, 1945

Where did injury occur? Edgewood Arsenal (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?): Industry

Means of injury: Explosion Injured at work? yes

23. SIGNATURE: Gerald C. Palmer M.D.
M.D. or other
Address: Bel Air, Md. Date signed: 5/25/45

DEPUTY MEDICAL EXAMINER
HARFORD COUNTY

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

CERTIFICATE OF DEATH

05071

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Francis McQuade

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Minna McQuade
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1871

8. AGE: Years: 73 | Months: 9 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa
(Town, county, and state)

10. Usual occupation: Janitor, Retired

11. Industry or business: U.S. govt, Edgewood Arsenal, Md

FATHER
12. Name: Unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs Minna McQuade
Address: Joppa, Harford Co, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 1945 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran
Location: Joppa Maryland

18. Funeral director: Howard R. McComas
Address: Abingdon Maryland

19. May 3 1945 Marie M. Mackadale
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1945 at 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 18 1944 to May 1 1945
and that I last saw him alive on May 1 1945

Immediate cause of death: Carcinoma of Pancreas — DURATION: 10 months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Fred O Hodous MD
M. D. or other
Address: Edgewood Md Date signed: 5-1-45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05172 PS-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred: 329 Strawberry alley
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 329 Strawberry alley
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Letonia Moore

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1900

8. AGE: Years	Months	Days	If less than one day
44	9	16	hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business:
FATHER 12. Name: George Moore
13. Birthplace: Md.
MOTHER 14. Maiden name: Annie Moore Mack
15. Birthplace: Md.
16. Informant: Susannah Christy
Address: Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3, 1945 (month) (day) (year)
Cemetery or crematory: Grace Hill
Location: Harford Co. Md.
18. Funeral director: W. Madison Mitchell
Address: Havre de Grace Md.
19. June 3 1945 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1945 at 8:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19__ to May 31 1945
and that I last saw her alive on 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	1-25-45
Due to	
Due to Mitral Insufficiency	7-1-40
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Claude L. Brown M. D. M. D. or other
Address: Havre de Grace Date signed: 6-2-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-B)

CERTIFICATE OF DEATH

Reg. Diat. No. 05073, 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 yrs
Hospital, Institution, or street address where death occurred: Harford Memorial Hosp
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nathaniel Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Ella Moore
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-4-1880

8. AGE: Years	Months	Days	If less than one day
65	2	20	..... hrs. ..... min.

9. Birthplace: Harford, Md.
(Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business

FATHER
12. Name: Robert Moore
13. Birthplace: Md.

MOTHER
14. Maiden name: Rachel Moore
15. Birthplace: Md.

16. Informant: Mrs Ella Moore wife
Address: 2 Harthorn Place Lynch

17. Burial, cremation, removal? (Which?) Burial Date thereof: May 26, 1945 (month) (day) (year)
Cemetery or crematory: Havana Cem
Location: Harford Co. Md
18. Funeral director: H.S. Bailey
Address: Darlington, Md.
19. May 24 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-24 19 45 at 3 55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-11 19 45, to 5-24 19 45 and that I last saw h[illegible] alive on 5-24 19 45.

Immediate cause of death	DURATION
Pneumonia	
Due to Carcinoma of tongue	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles H Tilghman M.D.
M. D. or other
Address: Havre de Grace Md Date signed: 5-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

~~BALTIMORE CITY HEALTH DEPARTMENT~~

CERTIFICATE OF DEATH

(59-2)

05674 P

Registered No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: (a) County Harford, ~~City~~, Maryland

(b) Street address 638 W. Bel Air Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in State (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Harford

(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)

(d) Street No. 638 W. Bel Air Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Newcomb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Amy B. Newcomb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22. 1865

8. AGE: Years 80 Months 2 Days 27 If less than one day hr. min.

9. Birthplace Bridgton N.J. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Isaac Newcomb

FATHER 13. Birthplace N.J.

MOTHER 14. Maiden Name Emma Brown

MOTHER 15. Birthplace Baltimore

16 (a) Informant Mrs. Amy B. Newcomb,

(b) Address 638 Bel Air Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-22-45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.,

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 747 St Paul St

19 (a) 5/21/45 (Date rec'd by registrar) (b) Alb. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1945 at 5 17 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1945, to May 19 1945 and that I last saw him alive on May 18 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	1½ days
Due to Hypertrophic arteriosclerosis (Colon).	Jan. 4 45
Due to Dental Caries	Jan. 4 45
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lewis P. Thompson M. D.

Address Aberdeen Md Date signed May 19 45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

T05075

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:

County: Harford

City or town: Whiteford Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Whiteford Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Norris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Henry J. Norris

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): May 5, 1863

8. AGE:

Years	Months	Days	If less than one day
82	0	23	...hrs. ...min.

9. Birthplace: Christiana Delaware
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joshua Lowe
13. Birthplace: Delaware

MOTHER
14. Maiden name: Mary E. Griffith
15. Birthplace: Delaware

16. Informant: Henry J. Norris
Address: Whiteford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31-1945 (month) (day) (year)

Cemetery or crematory: Rose View cemetery

Location: Wilmington, Delaware

18. Funeral director: Hubert P. Harkins

Address: Delta, Pa.

19. May 29 19 45 (Date rec'd by registrar) Carl E. Young Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1945 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to May 28 1945; and that I last saw h... alive on May 28 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to: Art. Sclerotic C-V	
Disease with	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Josiah A. Hunt M.D.
M. D. or other

Address: Cardiff, Md. Date signed 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of sex & color is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05076

(195-2)

FILM No. G 95 JUN 13 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Bldg. #509

How long in hospital or institution? Dead on Admission

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1633 Ashland Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Eleanora M. Oliver

3.(b) Social Security Number:

4. Sex: Female

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced:

6.(b) Name of husband or wife: Henry A. Oliver

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 21, 1909

8. AGE: Years	Months	Days	If less than one day
35	11	4	... hrs. ... min.

9. Birthplace: Sheppard, Virginia (Town, county, and state)

10. Usual occupation: Munitions Handler

11. Industry or business: Industry

FATHER 12. Name: Un Known

13. Birthplace: "

MOTHER 14. Maiden name: Un Known

15. Birthplace:

16. Informant: Henry Oliver

Address: 1633 Ashland ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26/45 (month) (day) (year)

Cemetery or crematory:

Location: Farmville, Va.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brant ley ave

19. 5/30/45 19... (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on dead on admission 19...

	DURATION
Immediate cause of death: Chemical burns	instant
Due to: White Phosphorus	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: May 25, 1945.

Where did injury occur? Edgewood Arsenal, Harford, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Industry

Means of injury: Explosion Injured at work? Yes

23. SIGNATURE: Gerald C. Palmer M.D., DEPUTY MEDICAL EXAMINER, HARFORD COUNTY, M. D. or other

Address: Bel Air, Md. Date signed: 5/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECORDS
JUN 2 1945
BUREAU V.R.

WITHIN CORPORATE LIMITS ☐

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05077

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford.
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 Erie St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Petroski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	~~Single~~ Married

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-17-'04

8. AGE: Years	Months	Days	If less than one day
40	6	0	..... hrs. ..... min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden name "
15. Birthplace "

16. Informant Hosp. Records
Address Havre de Grace, Md.

17. Burial Date thereof 5/19/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace

18. Funeral director Pennington & Rea
Address Havre de Grace, Md.

19. May 19 1945 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17 1945 at 8 15/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-15 1945, to 5-17 1945
and that I last saw h[illegible] alive on 5-17 1945

Immediate cause of death	DURATION
Miliary Tuberculosis	
Due to Tuberculosis of Larynx	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles N Fogg M.D.
M. D. or other
Address Havre de Grace Md Date signed 5-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

05078

GIVEN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 yrs
Hospital, Institution, or street address where death occurred: 563 Congress Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 563 Congress Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Kate Pierce

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Mar. 25, 1868

8. AGE: Years 77 | Months 1 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace: Cecil Co. Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: George Pierce
13. Birthplace: Md.

MOTHER
14. Maiden name: Susanna Seth
15. Birthplace: Md.

16. Informant: Mrs. Ellender Fleming
Address: Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1945 (month) (day) (year)
Cemetery or crematory: Cherry Hill Cem.
Location: Cecil Co. Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.

19. May 16 1945 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945 at 7 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 30 1945, to May 13 1945
and that I last saw h-er alive on May 12 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	
Antecedent causes: Hypertension	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: Coryza	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed: 5-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BC

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

05679

CERTIFICATE OF DEATH

Reg. Diat. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
Building 509
How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3523 Elmley Avenue, Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Cora M. Pyne

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Charles E. Pyne, Jr.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 18, 1903

8. AGE: Years	Months	Days	If less than one day
41	7	8	hrs. min.

9. Birthplace: Harford County, Maryland (Town, county, and state)
10. Usual occupation: Munitions Handler
11. Industry or business: Industry

FATHER
12. Name: Valentine Zeigler
13. Birthplace: Maryland

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Charles E. Pyne
Address: 3523 Elmley Avenue, Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29, 1945 (month) (day) (year)
Cemetery or crematory: Moreland Cemetery
Location: Baltimore Co., Md.

18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans Street

19. 5/28 1945 (Date rec'd by registrar) A. W. Hedrick per MP Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 PM., May 25, 1945, to 3 AM., May 26 1945
and that I last saw h... alive on May 26 1945

Immediate cause of death: Chemical burns — DURATION: 11 hrs
Due to: White Phosphorus burns
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: May 25, 1945
Where did injury occur? Edgewood Arsenal (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Explosion Injured at work? yes

23. SIGNATURE: Harold C. Palmer MD
DEPUTY MEDICAL EXAMINER HARFORD COUNTY, MD.
Address: M. D. or other
Date signed: 5/26/45

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITIES CORPORATE LIMITS ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

05680 T

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 yrs
Hospital, institution, or street address where death occurred: 516 Freedom Alley
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 516 Freedom Alley
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Emma J. Richardson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 26, 1880

8. AGE:

Years	Months	Days	If less than one day
64	7	5	hrs. min.

9. Birthplace: Havre de Grace Harford Co. Md.
(Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business:
FATHER 12. Name: George W. Richardson
13. Birthplace: Md.
MOTHER 14. Maiden name: Margaret Tower
15. Birthplace: Md.
16. Informant: Mr. Chas. Raymond Cooper
Address: Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4 1945 (month) (day) (year)
Cemetery or crematory: St. James
Location: Harford Co. Md.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.
19. May 4 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1945, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1944 to May 1 1945
and that I last saw h[illegible] alive on May 1 1945

Immediate cause of death	DURATION
Carbon Monoxide Poisoning	
Due to Hypostatic Pneumonia	
Due to Cerebral Hemorrhage	
Due to —	
Other conditions Leukemia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D.
M. D. or other
Address: Havre de Grace Md. Date signed: 5-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1950) (145)

CERTIFICATE OF DEATH

15081

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: HARFORD
City or town: RURAL - BELAIR
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2
Hospital, institution, or street address where death occurred:
FOUNTAIN GREEN HOSPITAL
How long in hospital or institution? 35 MIN-

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: HARFORD
City or town: RURAL - BELAIR
(If outside city or town limits, write RURAL and give nearest town)
Street No.: MECHANICSVILLE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME GLADYS MARIE RICHARDSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
FEM	WH.	married

6.(b) Name of husband or wife: CLARENCE RICHARDSON
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT. 7, 1908

8. AGE:	Years	Months	Days	If less than one day
	36	8	22	hrs. min.

9. Birthplace: VIRGINIA
(Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business
FATHER 12. Name: R M Reedy
13. Birthplace: Va
MOTHER 14. Maiden name: — Phillips
15. Birthplace: Va
16. Informant: Clarence M. Richardson
Address: Bel Air Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31-45 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Fountain Green Harford Co Md
16. Funeral director: Martin G Kurtz
Address: Jarrettsville Md.
19. 5-29 1945 (Date rec'd by registrar) Priscilla Townsend Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 29 1945, at 12:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944, to MAY 29 1945
and that I last saw h~~im~~ alive on MAY 29 1945

Immediate cause of death: "NITRITOID" Reaction To INTRAVENOUS INJECTION NEOARSPHENAMINE — DURATION
Due to: Followed By ECLAMPTIC STATE (2 CONVULSIONS + RUPTURE OF FETAL
Due to: MEMBRANES)
Other conditions: 6½ MOS. PREGNANT - MODERATE HYPERTENSION -
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. ~~or other~~
Address: Forest Hill, Md Date signed: May 29-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 1 1945
BUREAU V.A.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 115083 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs

Hospital, institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 N. Union Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John A. Russell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	13	..... hrs. ..... min.

9. Birthplace Havre deGrace, Harford, Md.
(Town, county, and state)

10. Usual occupation Laundry man

11. Industry or business

FATHER
12. Name S. Lewis Russel
13. Birthplace Maryland

MOTHER
14. Maiden name Julia Byard.
15. Birthplace Maryland.

16. Informant Deceased or Mrs Walter Barnes
Address 3603 Calloway Ave, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. May 1 1945 A. L. Lewis M. D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1945 at 5 03 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-26 1945 to 5-1 1945 and that I last saw h.. alive on 5-1 1945

Immediate cause of death	DURATION
Intra Cranial Hemorrhage	3 hrs.
Due to Hypertensive Cardiovascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles N Ingram M.D.

Address Havre de Grace Md. M. D. or other Date signed 5-1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CITIES CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-A)

CERTIFICATE OF DEATH

T

05083

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 3 months
Hospital, institution or street address where death occurred:
East Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No 9 Market St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Helen Mary Spicer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Elmer Spicer
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): August 28, 1923

8. AGE: Years	Months	Days	If less than one day
21	9		hrs. min.

9. Birthplace: Philadelphia Pa.
(Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business
FATHER 12. Name: A. Dunbar Hammer
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Hazel M. Snyder
15. Birthplace: Balto. County Md.
16. Informant: Mrs. Hazel S. Mouldale
Address: Aberdeen R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3 1945 (month) (day) (year)
Cemetery ~~or crematory~~: Bakers
Location: Near Aberdeen
19. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.
19 June 2 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 45 at 6:00 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carbon monoxide poisoning	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5/31/45
Where did injury occur? Havre de Grace (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Left heater on + went to sleep Injured at work? no

23. SIGNATURE: Gerald C. Palmer M.D. Deputy Medical Examiner Harford County M. D. or other
Address: Bel Air, Md. Date signed: 6/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BC

05084 C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Bldg. 509

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1021 West Fayette Street (23)
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Lucile Springer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed

6.(b) Name of husband or wife: –

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18, 1910

8. AGE: Years	Months	Days	If less than one day
34	10	7	..... hrs. ..... min.

9. Birthplace: Albany, Georgia
(Town, county, and state)

10. Usual occupation: Spray Painter

11. Industry or business: Industry

FATHER
12. Name: Isaac Bolden
13. Birthplace: Georgia

MOTHER
14. Maiden name: Sarah Bolden
15. Birthplace: unknown

16. Informant: Viola Miller (cousin)
Address: 947 West Lexington St., Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 31 '45 (month) (day) (year)

Cemetery or crematory:

Location: Newark N J

18. Funeral director: Mrs Katie R Williams

Address: 322 N Schroeder St

19. 5/29/45 (Date rec'd by registrar) A.W. Aldrich M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4:00 PM., May 25 1945, to 8:00 PM., 1945
and that I last saw her alive on May 25 1945

Immediate cause of death: Chemical burns — DURATION: 4 hrs

Due to: White Phosphorus burns

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of May 25, 1945

Where did injury occur? Edgewood Arsenal (City or town) Harford (County) Md. (State)

Injured at home, farm, Industry, public place (where?): Industry

Means of injury: Explosion Injured at work? yes

23. SIGNATURE: Gerald S Palmer M.D.
ASST MEDICAL EXAMINER HARFORD COUNTY
Address: Bel Air, M. D. or other

Date signed: 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(1)

7

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

05085

Reg. Dist. No. 125

1. PLACE OF DEATH:

County Harford

City or town Havre deGrace.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yr

Hospital, Institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre deGrace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 618 Linden Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-8-1945

8. AGE: Years — Months — Days — If less than one day 0 hrs. 5 min.

9. Birthplace Havre de Grace Harford Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Victor Wallace Taylor.

FATHER 13. Birthplace Los Angeles, Calif.

MOTHER 14. Maiden name Emily Parque.

MOTHER 15. Birthplace Mokanci, Arizona.

16. Informant Mrs Victor Taylor

Address 618 Linden Lane, Havre de Grace, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/10/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19. May 10 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945, at 6 59 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-8 1945 and that I last saw h.e.r. alive on 5-8 1945

Immediate cause of death	DURATION
Premature (6 mo)	
Due to Premature separation of	
Due to placenta	
Other conditions Prolapsed Cord.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H Ligon MD

M. D. or other

Address Havre de Grace Md Date signed 5-9-45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

T5086

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Del. County Del
City or town Wilmington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None ✓

3.(a) FULL NAME Jennie Tilden

3.(b) Social Security Number 222-09-1462

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife Robert Tilden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1885

8. AGE: Years 59 | Months 8 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Harford Co. Perryman (Town, county, and state)
10. Usual occupation Day Laborer
11. Industry or business Stone work
12. FATHER Name Philip Stansbury
13. FATHER Birthplace Perryman Md.
14. MOTHER Maiden name Lizzie Smith
15. MOTHER Birthplace Perryman Md.
16. Informant Mrs. Leona Hooks
Address 333 Ohio St Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19 1945 (month) (day) (year)
Cemetery or crematory Union M. E.
Location Near Aberdeen Md.
16. Funeral director Henry Fanning Sons.
Address Aberdeen Md

19. May 17 1945 (Date rec'd by Registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945, at 8:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1945, to May 15 1945; and that I last saw h alive on May 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5-14-45
Due to Arterio sclerosis	Dec '44
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Claude L. Lewis M.D. M. D. or other
Address Havre de Grace Date signed 5-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

05087

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:
Building 509

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2545 Robb Street
(If rural, give LOCATION)

2.(a) If veteran, name war — ✓

3. (a) FULL NAME: Mildred Grace West Todd

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Walter Todd, Jr.

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): February 11, 1919

8. AGE: Years	Months	Days	If less than one day
26	3	14	...hrs. ...min.

9. Birthplace: Havre de Grace Md.
(Town, county, and state)

10. Usual occupation: Munitions Handler

11. Industry or business: Industry

FATHER
12. Name: Hugh A. West
13. Birthplace: Harford County, Maryland

MOTHER
14. Maiden name: Emily B. Sampson
15. Birthplace: Maryland

16. Informant: Hugh A. West (Father)
Address: 560 Congress Ave Edgewood Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)
Cemetery or crematory: Rock Run Cem
Location: Harford Co Md.

18. Funeral director: R Madison Mitchell
Address: Havre de Grace, Md.

19. May 27 1945 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945 at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw h... alive on dead on admission 19...

Immediate cause of death	DURATION
Chemical burns	instant
Due to: White Phosphorus burns	
Due to: —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: May 25, 1945
Where did injury occur? Edgewood Arsenal, Harford, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Explosion Injured at work? yes

23. SIGNATURE: Gerald C Palmer M.D.
M. D. or other
Address: Bel Air, Md Date signed: 5/25/45

DEPUTY MEDICAL EXAMINER
HARFORD COUNTY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
MAY 29 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

T

05088 181

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2.6 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Gardner Thompson Umbarger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruth Kilby

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): March 15th 1900

8. AGE: Years	Months	Days	If less than one day
45	2		hrs. min.

9. Birthplace: Smith Co. Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: George C. Umbarger
13. Birthplace: Smith Co Virginia

MOTHER
14. Maiden name: Louisa F. James
15. Birthplace: Smith Co Virginia

16. Informant: Mrs. Ruth K. Umbarger
Address: Aberdeen Md - R. F. D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25th 1945 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Near Bel Air Md.

18. Funeral director: Bewley Fanning Sons.

Address: Aberdeen Md

19. May 25 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1945 at 2 20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925 to 1945

and that I last saw him alive on May 16 1945

Immediate cause of death: Coronary Thrombis (Complete Decision) — DURATION: Sudden

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W B Hopkins M. D. or other

Address: Bel Air Md Date signed: 5/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

05089 A

Reg. Dist. No. 180

BC

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
Building 509
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 823 North Streepen Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME
VOLA VALENTIN

3. (b) Social Security Number
—

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Henry
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1891

8. AGE:

Years	Months	Days	If less than one day
54	4	24	..... hrs. ..... min.

9. Birthplace: Baltimore, Md
(Town, county, and state)
10. Usual occupation: Munitions handler
11. Industry or business: U S Government

FATHER
12. Name: James Paul Finagan
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary E. Finagan
15. Birthplace: Baltimore, Md.

16. Informant: Earl Hayes
Address: 823 N. Streepen St., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29-45 (month) (day) (year)
Cemetery or crematory: St. Mary's
Location: Roland Ave
18. Funeral director: Wm. H. Valentine
Address: 2326 Aiken St.

19. 5/28 45 Alw. Heidrick (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 19 45, at 4: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
White phosphorous burns	
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 25 May 45
Where did injury occur? Edgewood Arsenal, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Explosion Injured at work? Yes

23. SIGNATURE: Leonard A. Palmer M.D.
DEPUTY MEDICAL EXAMINER
HARFORD COUNTY
M. D. or other
Address: Bel Air, Md. Date signed: 26 May 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

WITHIN CORPORATE LIMITS OF

CERTIFICATE OF DEATH

05090

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Bonford Memorial Hospital

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Harford

City or town Bel air Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME M.
Mrs. Ethel a Walter

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband ~~or wife~~ Charles S. Walter Sr.

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 21, 1890

8. AGE: Years 55 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Havre de Grace, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Robert L. Knight

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden name Hannah Hamblett

MOTHER 15. Birthplace Maryland.

16. Informant Mrs. Catherine Young

Address Bel air, Md.

17. Burial Date thereof May 27-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Tabor

Location Near Bel Air Md.

18. Funeral director Henry Tarring Sons

Address Aberdeen Md

19. May 24 1945 A. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-13 1945, to 5-19 1945 and that I last saw h... alive on 5-19 1945

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. L. Lewis M.D.
M. D. or other

Address Havre de Grace Md Date signed 5-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

05091 P

Reg. Dist. No. 180

BC

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? –

Hospital, institution, or street address where death occurred:
Building 509

How long in hospital or institution? dead on admission

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: –

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 831 West Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME Lena Washington

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Separated

6.(b) Name of husband or wife: –

6.(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.): September 28, 1906

8. AGE: Years	Months	Days	If less than one day
38	7	27	... hrs. ... min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Munitions Handler

11. Industry or business: Industry

FATHER
12. Name: unknown
13. Birthplace: –

MOTHER
14. Maiden name: unknown
15. Birthplace: –

16. Informant: –
Address –

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Brooklyn Md

18. Funeral director: Thos O. Wilson

Address: 1900 Bentley ave

19. 5/29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on dead on admission 19...

Immediate cause of death	DURATION
Chemical burns	Instant
Due to: White Phosphorus burns	
Due to: –	
Other conditions: –	

(Include pregnancy within 3 months of death)

Major findings of operation: –
Date of op. –

Autopsy results: –

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: May 25, 1945

Where did injury occur? Edgewood Arsenal, Harford, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Industry

Means of injury: Explosion Injured at work? yes

23. SIGNATURE: Benedict Robinson M.D.
DEPUTY CORONER HARFORD COUNTY
M. D. or other

Address: Bel Air, Md. Date signed: 5/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93:2)

CERTIFICATE OF DEATH

05092

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 yrs

Hospital, institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford.

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Allaire St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaac Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
86			..... hrs. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Norman Williams

13. Birthplace —

MOTHER 14. Maiden name Mandie Tilson

15. Birthplace —

16. Informant Dressed

Address Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)

Cemetery or crematory St. James C.M.E.

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. 5-29-45 19.... A. L. Lewis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26 19 45 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-25 19 45 to 5-26 19 45 and that I last saw h... l... alive on 5-26 19 45

Immediate cause of death	DURATION
Hypostatic Congestive Lung	
Due to Congestive Heart Failure	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles V Rigon M.D.

M. D. or other

Address Havre de Grace Md Date signed 5-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

105093

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 301 Lafayette St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Augustus Willis D.D.S.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie C. Willis
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 8, 1891

8. AGE: Years: 54 | Months: — | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Dentist

11. Industry or business:

FATHER
12. Name: George A. Willis Sr.
13. Birthplace: Va

MOTHER
14. Maiden name: Lavinia Ann Brambaugh
15. Birthplace: Va

16. Informant: Mrs Fannie C. Willis
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 1945 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Harford Co. Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. May 15 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1945, at 9 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr 6 1945 to May 12, 1945
and that I last saw him alive on May 12, 1945

Immediate cause of death: Uremic Coma

	DURATION
Due to: Chronic Nephritis	
Due to: Hypertension	
Due to: Coronary occlusion	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. L. Lewis M.D.
M. D. or other
Address: Havre de Grace Md. Date signed 5-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15